STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003776	A. BUILDING _____ B. WING _____	01/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IU HEALTH WEST HOSPITAL	1111 N RONALD REAGAN PKWY AVON, IN 46123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for 1 (one) State hospital complaint investigation. Complaint: #IN00094372 Unsubstantiated; lack of sufficient evidence. Facility: #003776 Date: 1-18-2012 Surveyor: Karilyn M. Tretter, RN Public Health Nurse Surveyor Indiana University Health West Hospital is in compliance with 410 IAC 15-1.6.7, Respiratory care services, 410 IAC 15-1.5-7, Pharmaceutical services, and 410 IAC 15-1.5-6, Nursing services, Indiana State Hospital Licensure Rules. QA: claughlin 01/25/12	S 000		